

Medical Advisory Committee

Minutes

Friday, September 16, 2005

Labor and Industries Building, Conference Room F

Members Present:

Pam DeVisser, FNP

Tim Keenan, MD, Vice Chair

Hans Carlson, MD

Linda Jefferson, CPDM, Employer Representative

Maria Carraher, Worker Representative

Brad Lorber, MD

Frank Prideaux, DC

Gary Rischitelli, MD

Franklin Wong, MD MCO Representative

Members Absent:

Ronald Bowman, MD, Chair

Linda Olsen, Insurer Representative

Tom Williams, PT

Staff Present:

Nancy Bieber, Workers' Compensation Division

Debra Buchanan, Workers' Compensation Division

Nathan Johnson, Information Management Division

Barry Jones, Workers' Compensation Division

Sandra Savage, Workers' Compensation Division

Donita White, Workers' Compensation Division

Kevin Willingham, Workers' Compensation Division

Medical Quality Initiative Update

Nathan Johnson, Information Management Division and Donita White, WCD, updated the committee on meetings with customers regarding medical reporting requirements. The Department currently receives from insurers cost data as required in Bulletin 220. The Division is considering adding a few more data requirements regarding provider type and is seeking feedback on this. Right now, the data the department is receiving is somewhat limited regarding provider types. The difficulty in interpreting the data is that because of the way the date is reported, treatment can be attributed to a physicians' group, rather than to an individual doctor. Geographic data can also be unreliable because the zip code noted is not always for the location of treatment, but instead for the location of the billing office. Input from various members of the group highlighted other problems encountered in extracting data from medical reports; multiple procedures may be lumped together under one code, reports also make use of HCPC and NDC codes, and the number of digits may vary from one code format to another. To sum up, Nathan

would like the members of the committee to contact him with their ideas of what data they wish to be gathered.

Barry Jones gave a progress report on the Medical Quality Initiative. There will soon be a series of external stakeholder meetings. The main goal of the MQI is to get a handle on medical inflation costs. The group discussed the fact that there were many ideas and suggestions internally, however, the division wants to make sure that the stakeholders know the division values their ideas and opinions and have not already decided the outcomes of this project. The first meeting is scheduled for Medford on October 26th. Other meetings will probably take place in Salem on November 18th, and Portland on November 19th. The meetings will be open to all the different types of stakeholders; attorneys, physicians, injured workers, insurers, etc.

Dr. Keenan was concerned that if someone is not there from the division to moderate the proceedings, it would be difficult to keep the direction of the meeting on track and could prevent all stakeholders from being heard. Barry stated that the ground rules for the meetings will be spelled out beforehand. There will be a pilot meeting in Salem on October 4th.

Dr. Wong expressed his concern that there are 7 potential goals for the MQI, and 3 potential strategies for achieving them, but there has been no definition of what is considered quality, and no means of tracking results. Barry responded that these meetings are just a first step. They will help determine what ideas the stakeholders wish to explore, and examine what is feasible. There was discussion about the form that the breakout sessions for these stakeholder meetings would take.

Senate Bill 311

Debbie Buchanan, WCD, reviewed the requirements of Senate Bill 311 with the committee, along with MLAC agreements, policy and rulemaking processes. SB 311 addresses independent medical exams. Pam DeVisser wanted to know if IME physicians would need to be specialists in the type of injury which the injured worker suffered. Debbie said that this hadn't been decided yet and these issues would be addressed in the next 6 months in the administrative rules process, with stakeholder involvement. One of the SB 311 requirements is that sanctions be assessed for medical providers who fail to make medical records available for IME's. This concerned Dr. Keenan, who pointed out that physicians are often at the mercy of delivery services who transport x-ray films. X-ray films are often in transit limbo, taking unusually long periods of time to reach their destination. Linda Jefferson noted the term IME can cause alarm to workers. She also noted that many doctors feel busy enough as it is and may believe that they don't have the time to meet the education requirement for IME physician certification. Kevin said that in-class training may not be necessary. There was discussion regarding Washington's requirements, that they apparently simply require that physicians read a pamphlet and answer a questionnaire at the end. Linda Jefferson wanted to know if the rule against the presence of paid observers precluded the presence of translators at an IME. Debbie commented that translating seemed to be different from observing, but that it could be addressed in the rules process. Maria Carraher wanted to know if an injured worker's spouse attends an exam as an observer, was the spouse then prevented from testifying at a hearing as a witness. Kevin Willingham commented that this did not seem to be the intent, and that through more precise wording, the rules could be made clear on these matters. Dr. Keenan feels that IME doctors should look at the most recent x-rays

and MRI films when conducting their evaluations, and not simply rely on the radiologist's report. There was discussion regarding an MLAC agreement for the attending physician to be required to review the IME report with the injured worker within a set time frame. There were several concerns around this including the patient physician relationship and possible increased costs to the system for an extra exam with the attending physician. MAC decided to send John Shilts a memo on the topic noting their opposition to the requirement.

Medical Policy Development

The committee began a discussion of medical policy development at the July meeting. Kevin, along with members of WCD Administration, the MQI project team, and Debra Buchanan, manager of the Medical Review Unit, took the comments from that meeting and narrowed them down into 5 parts to test these ideas with the committee. They are:

- Containing inflation: system should have effective controls that decrease overall claims costs.
- Effective and appropriate medical care: system should provide injured workers access to timely, quality and consistent medical treatment and services. Thus, improving return-to-work and vocational-functioning outcomes.
- Appropriately managed medical care in the WC system: medical providers should manage treatment and services. System should be free of unnecessary paperwork and other "hassles".
- Comprehensive public policy: system integrates claims management to facilitate medical-benefit delivery. Workers do not have to fight for benefits.
- Coherent medical policy: system provides incentives to achieve goals for all. WC medical policy aligns with Oregon's medical policy. System based on trust of participants and provides common understanding of terms.

Kevin asked "What is quality?" Kevin also wanted to explore the topic of psycho-social factors that may hinder healthcare in workers' compensation in contrast to private health care. "What are these factors?" and "How can we address them to improve outcomes for workers?" Kevin is aware of studies that identify these psycho-social factors, but is unaware of any studies that identify how you overcome these problems. Maria Carraher suggested that you look at the employers. She hears complaints from injured workers who say their employer hates them because they got hurt, and co-workers are angry because they ruined their safety record. Linda Jefferson agreed that many problems stem from conflicts with employers or co-workers. Kevin asked, when a doctor realizes that there are psycho-social factors involved in an injury, when do you address those factors? One member of the committee said that it begins as soon as they begin filling out the forms. It was noted that some injured workers are concerned their employers work them too hard and don't care about them. Workers are also concerned they will be sent back to the same job no matter what the doctor orders, and will get hurt again and lose their job. Dr. Rischitelli noted data that showed time loss outcomes improved remarkably if the employer simply called the injured worker at home to ask how he or she was doing. He also noted a study done in Michigan which looked at the ten employers with the best time loss records, and the ten worst, over ten years. Employers and managers of these companies were interviewed, and it was found that in those companies with the worst records, both managers and

employees said that the company did not value its employees. Another finding was that a factor affecting time loss can be co-dependency that can sometimes develop between physician and injured worker. Dr. Prideaux noted the potential effect of cultural differences in the process and in some injured worker expectations. Dr. Rishcitelli said that claims examiners don't always acknowledge these factors because of concerns that if they do, these factors could then become an issue in the claim. Kevin asked that Dr. Rishcitelli send him copies of the studies he mentioned so that they can be distributed before the next MAC meeting. It was also noted that education for some insurers may be needed in some instances.